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Editorial

PSYCHIATRY AND THE GENERAL PRACTITIONER

How much psychological illness is to be seen in general practice? How much should the G.P. reckon to treat himself? How much is he taught, and how much should he be taught, about the subject—before or after qualification? These have been important questions for some time: they are now even more vital to consider in view of the policy behind the new Mental Health Act.

We are therefore publishing a special number on this subject, and have invited contributions from several G.P.s who have already written on this subject—Dr. Watts, Dr. Horder and Dr. Franklin —and we are very grateful for their papers, which follow herewith. They are by no means unanimous in their views; as Dr. Franklin points out, a great deal more research is needed before we can answer the first question at all accurately. They do, however, agree that there is now more psychological illness to be seen in general practice than there was before the war, and they agree on the G.P.'s need to know more about it.

Why this increase should exist is the subject of doubt. Some blame the increasing stress of modern life, but Dr. Franklin does not believe that this stress is increasing: on the contrary, "it is probably much less than in former times". Mathematically, comparison of the stresses on us all today with those on our ancestors is most difficult, if not impossible: but Dr. Franklin's point of view would perhaps be supported by the incidence of higher suicide and neurosis rates in countries (e.g. Sweden and Denmark) which have most developed systems of social welfare. It is certainly something to bear in mind when we advocate more schemes of social security. On the other hand, Dr. Franklin quotes other figures, suggesting that in the U.S.A. there is a very high rate of psychological illness among the "bottom social scale" and only 10 per cent of this is neurosis. He goes on to blame the National Health Service, which has "swept aside the barrier of a fee" and so released a flood of psychiatric illness on to the G.P., which is by no means welcome to all.

Dr. Horder and Dr. Watts see this increase as a challenge, and as one to which the G.P. can respond with efficiency and pride—if only he has adequate training. Dr. Horder deplores the tendency, e.g. in the U.S.S.R., to refer all psychiatric patients at once to psychiatrists. This, indeed, would imply a vastly increased number of psychiatrists, unlikely to be achieved here, even if it is (apparently) so in certain cities in Russia. Leaving questions of staffing apart, there are other reasons why the G.P. should treat many psychiatric patients, for Dr. Horder feels he is not only someone who *can* do so, but someone who is in a better position for this purpose than any one else.

The reasons for this are, of course, not only that he knows the patient's background and his personality before his illness, but also that his standing in the eyes of the patient gives him—or should give him—an advantage in simple psychotherapy; a strange psychiatrist working in a hospital some way off—and perhaps a little awe-inspiring if he is known to be based on the staff of the local mental hospital—has many resistances to overcome before he can start on the same level. (In parenthesis, it may be remarked here that these difficulties could often be diminished by improving the system of referral and communication, which is often inadequate and inconsidered.)

But this means the acquisition of some skill on the part of the G.P. Dr. Watts outlines the skills required in dealing with the commoner syndromes: and states his own satisfaction at using them. How are they to be obtained?

We have asked Dr. T. P. Rees to write on training courses and opportunities. Besides his work on the Royal Commission, Dr. Rees is, of course, known for his pioneer work in educating the community while superintendent of Warlingham Park; and, more recently, for organising the N.A.M.H. refresher courses for G.P.s. His survey of the existing facilities is a comprehensive one: but there remain many G.P.s who have had no such course—and in any case need much more than the small amount of information which can there be provided: for, as Dr. Rees says about a typical course, it can only hope to provoke discussion and thinking. There is obviously little opportunity for developing skill.

To provide the latter, the groups initiated by Dr. Michael Balint must rank as the most effective means yet developed. They have been described fully on several occasions, notably in his book *The Doctor, the Patient and His Illness*, and that written jointly with Dr. Enid Balint, *Psychotherapeutic Techniques in Medicine*. Dr. Horder rightly praises the value of these group discussions. But the seminars are still only available on a relatively small front, and if more are to be provided, more demand must come for them —from general practitioners.

Psychiatric Skills in General Practice

By C. A. H. WATTS, M.D., D.R.C.O.G.

The teaching of psychiatry to students 30 years ago was meagre in the extreme. In the general wards we were taught scientific medicine and there every disease appeared to have a clearly defined etiology. It was due to congenital abnormality, inflammation, neoplasia and so on, and at the end of the list was hysteria. Every disease, it seemed, could be simulated by hysteria. We gathered that this was a rather disreputable condition; but beyond that no effort was made to explain what was meant by the term, or how to deal with the patients who suffered from it.

For a short spell we were given lecture demonstrations in a lunatic asylum. It was an eerie place with the locked doors and the curious, pathetic inmates shuffling round in shapeless, illfitting clothes. One learned that there were two main types of mental illness, and we were taught how to fill in a form to have such cases certified and put out of circulation. Of treatment there was none worthy of the name.

No "Pigeon-Holes"

On entering general practice there were fortunately very few psychotics to be certified. There were however many patients who would not fit into the neat scientific pigeon-holes, about which we had learned so much in the hospital wards. They were irritating people because it never seemed possible to satisfy them or to cure them. When they entered the consulting room my heart used to sink as I realised that I was in for yet another fruitless session. I felt anything but "a clever young doctor", and when at last the patient was ushered out of the surgery, there was relief, but no satisfaction; and yet in spite of the hopeless inadequacy of my "treatment", these people came back for more!

During the war I had the opportunity to work in a military psychiatric hospital, and there I learned a new approach which helped me considerably with this type of patient. Since coming back into general practice, I have found that I can do a good deal for most of these people, and that the treatment is a source of great satisfaction.

Even today, the "functional" type of patient receives little sympathy or attention, either in general practice or in hospitals. If they are to receive proper attention, then this is an art which should be taught to medical students and cultivated by family doctors. It is essentially different from the approach to organic disease. To be equipped to tackle psychiatric problems is so much more satisfying for both the doctor and the patient, and it is not as time-consuming as most people imagine. The beginner will

undoubtedly have to spend long hours on problem cases, but during this time he will also be perfecting the art, for although the bare bones of the technique can be taught and explained like any other skill in medicine, it has still to be perfected by practice.

Challenging Cases

The first step is to convince the present or future general practitioner that patients presenting with functional types of illness can be helped. Each case is a challenge. Instead of getting rid of them as quickly as possible, they should be given time to unburden themselves. If this promises to be a lengthy process in the middle of a busy surgery they should be given special appointments, and great pains should be taken to set their minds at rest, and to make them feel welcome. This is necessary to counter such remarks as, "I feel that I am wasting your time, Doctor," and, "I know that you think there is nothing wrong".

There will be little trouble in identifying this group of patients for within a short time of qualifying, most doctors are able to differentiate the patients who are suffering from an organic diagnosis such as angina pectoris from those with some sort of psychiatric trouble. In the latter the symptoms are not typical of organic disease, and intuitively the doctor realises that the trouble is functional in origin. With greater experience it is possible to sort out these psychiatric cases into various categories.

Next, the doctor must encourage his powers of empathy; that is of entering into the feelings of his patient. With the manic patient he feels cheerful, depressed with the melancholic, and confused by the pseudo-philosophic ramblings of the schizophrenic. With anxious people he should be on the lookout for clues which will lead him to the real cause of anxiety. It is just as important to discover the patient's own conception of what is wrong, as for the doctor to form his own opinion. There are in fact often two diagnoses; that of the patient and that of the doctor.

Uncharted Seas

Many doctors can be persuaded to take the first step which is no more than recording a psychiatric history, but after that they tend to retreat in panic because they feel that they have launched themselves into uncharted seas, they have no idea where to go once they have started, or what they are likely to meet. Even the diagnoses in this realm seem nebulous, difficult to pin point, and the variety of conditions seem to be legion.

In point of fact, just as in the old lunatic asylum days there were only two main diagnoses, so today in general practice there are only two main groups into which the patients fall. The vast majority of psychiatric casualties that we see are either anxious

or depressed: schizophrenia, addictions and organic psychoses are comparative rarities. The general practitioner then, needs to be equipped to deal with anxiety and depression, and to bear in mind any other conditions which are likely to occur very occasionally. When the unusual case does turn up, one gets the collector's thrill of finding the rarity. Each patient is of course different from all others, and the whole art of psychotherapy lies in treating people as individuals. This form of treatment is a two-edged sword, in that it is both a diagnostic tool and a form of treatment.

Anxious Patients

This is the commonest psychiatric problem of general practice. The patient must be made to feel at ease, and that his symptoms however mundane or bizarre are real, important, and well worth investigating. The doctor must appear to have all the time in the world, and no other interest than the patient for the duration of the consultation. It takes quite a lot of courage for the anxious patient to visit the doctor. The actual consultation is often preceded by quite a period of indecision. The patient feels at one moment that she must go and see the doctor, and face up to the things which frighten her; and then she changes her mind and feels that she is probably making a fuss about nothing. Her fears then return once more with renewed force, and this wavering attitude can be a most distressing situation. The anxious patient may realise that she is worried, and even know why she is worried, and yet be unable to solve her own problem.

Janet was an unmarried farmer's daughter of 25, who was house-keeping for a neighbouring farmer and his family. She came along complaining of headaches, vertical in situation, but not typical of organic disease. A complete physical examination was negative. It is quite useless to tell a patient that there is nothing wrong, or even that she has nothing to worry about. In the first place there is something wrong, and in the second if the patient is dismissed without delving into things, she tends to go away feeling that hers is too obscure a problem for the doctor to solve. One must know more of what is going on in her mind.

Janet was told that there was no evidence of organic disease, and that her headache was due to nervous tension, and that it was necessary to look for the cause of the tension. It seemed she had been helping out on the other farm, as the farmer's wife had been very ill; she had in fact died six months ago. The cause of death was cerebral tumour. *Janet* wanted to know if this type of disease was in any way catching. She was worried as she had heard of other cases in the area. A frank discussion cleared the matter up, the whole consultation taking about half an hour. A beginner would probably need to take longer, but experience teaches one short cuts,

and one can usually tell when the patient has unburdened herself and is feeling reassured.

Far from telling her there was nothing wrong, time was spent in explaining the mechanism of her fears in language she could understand. There is no place for jargon in psychotherapy. The essential thing is to make the patient feel confident, at ease, and able to talk. *Janet's* terrible fear of cancer which she dare not broach herself was easily debunked once it had been uncovered.

Just as intuition helps the tyro to differentiate the functional case from the organic, so it helps the expert to make a more accurate diagnosis; to realise that he is dealing with a problem of anxiety. The patient is alert, interested in the type of approach, eager to discuss problems, but she does not bring them all out in an uninhibited stream during the first five minutes of the interview. One can almost sense that the patient's confidence is building up, and her questions tend to be very much to the point. The patient often leaves saying that she is glad she came, and that already she feels a lot better.

Depressed Patients

The second type of patient to be aware of is the depressed person. The problem is extremely common, and is often overlooked or misdiagnosed as a case of anxiety. Anxious people can be depressed, but there is an endogenous type of depression which is an entirely different type of disease, with different features, and it requires a different treatment.

The depressed person is not radically assisted by explanation, interpretation, and reassurance such as was used on the patient *Janet*. The "feel" of the depressed patient is not like that of the anxious person. She is not alert, nor is she interested in the psychotherapeutic approach to her problem. She may have a ready made explanation for her symptoms, such as a cancer, or venereal disease, and she may reveal intimacies in her life in the early part of the consultation in a way which is out of keeping with the normal person. The anxious person may fear that she has a disease; the depressed person is sure that she has it.

There are certain other features which guide one to the diagnosis. There is usually a marked falling-off of energy, and she has to push herself to do the routine jobs. The avid reader drops her books and can only glance at the daily paper. Weekly letters to parents or children are scamped or not written at all. Insomnia is present in one form or another. Typically it is of the early waking type. There is frank depression which is evident in tears, a fear of dying, a fed-up feeling or even a wish to be dead.

There is a mood swing which is often quite marked. The patient may feel quite well one day, and in the depths of despair

the next. Often she feels at her worst in the morning after waking too early, but by nightfall feels not too bad again. She is liable to attacks of panic; gets feelings of apprehension which she may find hard to describe. It may come out with such phrases as: "Every time I hear a car stop, they are bringing my husband home from the pit." "When the phone goes, I feel sure that it is bad news." There is usually an increase in irritability, and the mother finds herself snapping at the children, and then feels sorry for what she has done. All these subjective feelings make her feel very inferior and inadequate. In fact she often thinks that she is getting neurotic and should be able to pull herself together.

The profound mental hospital type of depression is usually easy to recognise, but this mild type is often overlooked, and every family doctor should be trained to recognise these patients. There may be a suicidal risk in some of these people, and if there is any question of this, the patient should be referred to a psychiatrist without delay. The mild forms, even if devoid of this risk, give rise to much misery and loss of work. The first essential is to be aware that this is a common condition.

Jean was a young housewife of 23. She came along complaining of indigestion, and as with *Janet*, the physical examination was negative. *Jean* looked miserable and depressed. She readily divulged that she knew she had a growth, and she was sure that no one could help her. The illogical way in which these patients think was shown by her insistance that her case was hopeless and too late to be helped, and a moment later she was asking for X-ray investigations. She was given anti-depressive drugs which she accepted without any enthusiasm. In fact the depression cleared in a few days, in spite of herself and she just could not believe that a few tablets could make her feel so well, or alter her way of thinking.

All depressions do not respond to drugs with such gratifying rapidity, indeed some do not respond at all. If the symptoms do not clear in a few weeks, the patient should be referred to a psychiatrist as electroconvulsive therapy may be needed. The beginner is advised to keep in touch with a psychiatric colleague until he has learned how to handle these patients.

The Elderly

These two problems of dealing with anxious people and depressed people are the major psychiatric categories of general practice. No article on psychiatry in general practice would be complete without some reference to the handling of mental illness in the aged which is a large and ever growing problem confronting the family doctor. There is more mental disease and there are more suicides among the aged than in any other age group.

The two factors which cause most trouble in old age are loneliness and the increasing awareness of waning powers, and thus dependence on others. Every effort must be made to allay these two social dangers. Independence must be maintained as long as possible, loneliness must be circumvented. Old people are very prone to endogenous types of depression. Some respond well to antidepressive drugs, and age is no bar to electroconvulsive therapy.

A great deal of the impedimenta of old age are accepted too complacently. If grandpa starts being childish, the family tends to accept that it is the end, and nothing can be done. Some cases do go downhill no matter what treatment is tried, but many deteriorate simply from lack of stimulation. Enthusiasm to rehabilitate the patient on the part of the family doctor will go far to help the relatives to do their share in this important problem.

The Chronic

Finally let it be emphasised that the psychotherapeutic approach is no cure-all. There still remain in one's practice scores of chronic psychiatric problems for which there is apparently no definite remedy. Sometimes nature effects a cure after years of invalidism. Sometimes a modern drug will give marked relief to one such patient; but on the whole, like the poor, they are always with us. If they cannot be cured, they have to be maintained, and with my psychiatric training, I no longer feel conscience-stricken, or irritated by them.

If one realises that they are in a state of chronic depression, or anxiety, or that they are paranoid, or simply inadequate personalities, one is more tolerant towards them, and this helps both the patient and the doctor. I can honestly say that today only very few patients make my heart sink into my boots when they enter the consulting room. In psychiatry more than in any other branch of medicine the French adage is true : "Cure sometimes, relieve often, comfort *always*".

The Future of Psychiatry in General Practice

By JOHN HORDER, M.B., B.Ch., M.R.C.P.

Psychiatry has always been one of the general practitioner's tasks in the past; we have to ask if it will remain so in the future.

I have in mind the broadest possible conception of psychiatry. Whenever a doctor has a general concern for his patient and does not limit himself to a special task, he must watch the patient's thoughts and feelings. The general practitioner in the last 150 years (and before him the physician and the apothecary) has inevitably had to deal with psychiatric problems. He has been traditionally concerned with the whole patient and has a comparatively intimate relationship to him, so that he finds it easy to detect anxieties which arise over any medical problem; most illnesses are accompanied by anxiety. In specifically psychiatric illnesses the general practitioner has usually been the first helper to be approached; if the illness has presented itself in a physical way he has sometimes been the only person to go to; thus he has always dealt with psychosomatic illnesses, which are not a new development in this century. He has been called in for psychiatric emergencies because he is usually the nearest available helper. He has, in fact, needed to cope at one time or another with almost every psychiatric problem; this he has done sometimes well, sometimes badly and often without understanding precisely what he was doing.

Challenge to Tradition

This tradition now meets a sharp challenge. "Psychiatry is too complicated for general practitioners; all of it ought to be carried out by psychiatrists." This view is held on a wide scale in the U.S.S.R.; in some Russian cities there are apparently enough psychiatrists for them to be deployed on an area basis so that patients can go direct to them even with small problems. The view is a reasonable one and has its advocates in other countries too: but in the United Kingdom few believe this and fewer still act upon it. Specialist psychiatric help has to be obtained through an intermediary; there are many intermediaries and the general practitioner is one of those most frequently approached. Does this happen because this is the best system or because there are too few psychiatrists to do it any other way?

I think that we really do believe that this is the best system, at least for this country. We believe that the general practitioner can continue his traditional function in psychiatry because his place in the community fits him for this; for he is accessible, knows his

families, usually has their confidence (since they chose him), and is unhampered by those prejudices which still worry many patients when they consult psychiatrists; and is the natural person to go to about those physical complaints which are the presenting symptoms of much mental and emotional illness.

We believe at any rate that this *could* be the best system if general practitioners had the knowledge and the skill to make the most of the opportunities that crowd their way. This is the crucial point—the gap between what general practitioners do and what they could do—and this is why I shall devote a large part of this article to the question of training.

Rôle of the G.P. in Mental Health Care

Two months ago the World Health Organisation considered the rôle of the general practitioner in mental health care. (Expert Committee on Mental Health). It took the view expressed here that even where or when there are enough psychiatrists, the general practitioner has a wide and clear rôle in psychiatry.

He is concerned with *prevention, detection of cases, diagnosis, treatment, referral* and *rehabilitation*. He may also be concerned with promotion of mental health, but since none of us know how and when we promote mental health, this is uncertain.

He *prevents* certain mental disorders for he has indisputable opportunities to treat physical conditions which have mental components, such as syphilis, myxoedema, industrial poisonings, and brain damage at birth due to injury or anoxia. But how few are these conditions compared with the great mass of mental illnesses. We cannot prove that schizophrenia or manic depressive illnesses can be prevented. With neuroses, prevention may be possible, though hard to prove. Certainly the general practitioner has a vast field in the prevention of unnecessary anxiety in his patients. He may also (we believe) play a rôle in the prevention of life-long personality disorders by the way he deals with the problems of mothers and young children.

In the detection of cases, he is particularly concerned when mental disorder presents itself in a physical disguise; this it often does. Great diagnostic skill may be required to distinguish it from a primary physical illness. He is also frequently called upon to decide what is or is not within the limits of normal behaviour.

Diagnosis is still the general practitioner's most important rôle and in mental problems his scope is limited chiefly by his own ability. Some attempt at diagnosis he must make because the whole conduct of the case afterwards depends on his assessment. If he is interested and experienced, there is nothing to prevent him assessing the problem very fully but this takes time and he will only give this if he sees that problems of mental illness are important and

can have a more long-lasting influence than some more immediately urgent physical problems.

In *treatment* the general practitioner must know his own limitations. He can go so far, but not as far as the psychiatrist. He cannot give E.C.T. or carry out a formal psycho-analysis. There are scarcely any general practitioners, on the other hand, who do not use physical means, such as psychotropic drugs, to deal with psychiatric problems. There are no general practitioners who do not use psychotherapy since this includes the help which comes to the sick person through the mere presence of the doctor. On the other hand, there are not many who use psychotherapy in any conscious or planned way. Most of us do it untaught, but can psychiatrists claim to be in a very different position? Certainly we listen to people, try to understand them, pinpoint what seems to us important in their problems, advise them, reassure them (usually too much) and use suggestion. Sometimes, if we have the experience, we may try to uncover an unconscious problem. Very frequently, whether we are aware of it or not, we provide a long-term relationship and sometimes we succeed in making this relationship therapeutic.

Referral is an art. One can refer a patient to a chiropodist with a letter but without art; not so to a psychiatrist. Success depends on preparation. It is up to the general practitioner to see that the patient understands what is happening to him and what sort of doctor and treatment he is going to put his trust in. Referral must appear clearly as a door opened to further help and not as rejection.

Rehabilitation is less frequent a problem to the general practitioner than most psychiatrists imagine—nevertheless it is important. He can help the patient to make the change back from dependence to independence. He can help restore self-confidence which so often suffers a big blow because of mental illness. He can help with practical problems of jobs and housing. He can help the family to accept the patient back—a task which is sometimes very difficult.

In all these tasks the general practitioner will have constant opportunities for co-operating with others—not only psychiatrists and their staffs, but other medical agencies such as the medical officer of health and his staff; also with parents, clergy, schoolteachers, solicitors and probation officers—the list could be greatly extended.

It is stupid to pretend that these tasks can be carried out today without training. Traditionally the general practitioner has had less training, whether in psychiatry or in any subject, than any other sort of doctor. In an age where his responsibilities increase with every advance in medicine, this position is untenable. He needs post-graduate training as much as any specialist.

There are reasons for wondering whether the general practitioner needs post-graduate training in psychiatry *more* than he needs it in any other subject. Public interest in psychiatry and therefore the conscious need of his patients, has greatly increased; for this and other reasons psychiatric problems are occupying a larger proportion of his time, whether he likes it or not. Whole-patient problems are becoming more clearly his special field, as specialists increase their skill to deal with the problems of particular organs and systems of the body: whole-patient problems are frequently psychiatric.

Psychiatry, in the wide sense used here, cannot be taught entirely in the undergraduate period; it needs personal experience of patients and of life by the doctor who is being taught; it is best taught at a time when the doctor already has responsibility for people.

In the undergraduate period, there has already been an increase in the proportion of psychiatric teaching in the last 20 years. There are great variations between different medical schools and some of them do not yet reflect in their curriculum the great importance of the subject. Perhaps the main needs now are that the attitudes of those who teach general medicine, surgery and special subjects should change further towards tolerance and an interest in the patients' feelings and social situations; psychiatry in its wide sense is not a special subject but needs to permeate all medical teaching. The other need is even harder to achieve but experiments are already being made; the student needs experience of the problems that crop up in a continuous relationship of responsibility for a patient; this is something that is being lost as teaching becomes increasingly theoretical and increasingly fragmented; the doctor-patient relationship is too important a subject to be left to the student to grasp unaided; he will have the best chance of understanding something about it if he is allowed to have continuous supervised responsibility for one or two patients and can discuss the problems that arise.

Post-graduate education for general practitioners is voluntary in this country; they have no obligation, after the pre-registration hospital posts, to undergo any further training before starting to practise, nor to attend refresher courses as the years go by. But increasingly they need both these types of post-graduate training, and not least in the psychiatric aspects of their work. A great number of courses in psychiatry are now open in all parts of this country—some short, some long.

The most far-reaching effort is made in the type of course which originated in the Tavistock Clinic wherein a small group of doctors meets in the presence of one or two psychiatrists once weekly for two or three years. The doctors present their own cases. The doctor-patient relationship is the central subject of study;

a comprehensive training in psychiatry is not the purpose. The doctors gain some understanding of their own involvement and consequently gain in ability to use themselves effectively. They gain confidence in dealing with the many patients who complain but have no organic lesion. The long duration of the course allows long follow-up and the patient's troubles are more easily seen as a meaningful phase in their life. These courses are no longer confined to London; they are now over-subscribed.

When medicine, including psychiatry, is undergoing such rapid changes, one wonders whether it is any longer justifiable that refresher courses should not be obligatory for general practitioners; at present they are attended by the more enthusiastic doctors and not by those who most need them.

Summary

It seems that the general practitioner will continue to play a large part in the psychiatric care of our population. His rôle in medicine is changing; in psychiatry it may be enlarging to meet what seems to be an increasing need. A forthcoming report of the World Health Organisation devotes special attention to the general practitioner's rôle alongside that of the public health officer.

The general practitioner cannot grasp the opportunities which come his way, especially in psychiatry, unless he has better training than he has had in the past. Many encouraging experiments are being made but as yet they affect only a minority of doctors.

Psychiatric Illness in General Practice: The Urgency of the Problem

By L. M. FRANKLIN, M.R.C.S., D.P.H.

No one knows how much psychiatric illness a general practitioner sees, for attempts to measure it have provided inconsistent answers. For instance, a group of eight G.P.s in Sheffield[1] found that in 1947 6.5 per cent of their consultations were for "mental ill health", while another group of G.P.s[2] in 1953 stated flatly that 60 per cent of a G.P.'s patients present neurotic symptoms. A working party of the College of General Practioners[3] said that 30 per cent was the generally accepted figure for the incidence of psychological illness among people who consult a G.P. but they gave no evidence to support this figure.

The difficulty in measuring the amount of mental illness seen by G.P.s results from the absence of any agreed system of classifying mental illness. There is no agreement as to whether a particular condition should be regarded as psychiatric, and the standards of measurement vary from doctor to doctor. In this situation it is scarcely worth while for any more individual G.P.s to try to measure how much mental illness they deal with. This is a job for a team of professional research workers, and even they will not find it easy.

Nevertheless, most G.P.s feel that it is increasing, and this may well be so. This, of course, is not to say that the total mental illness in the population is necessarily increasing. There is certainly no evidence that the stress of life is now greater than in former times,[4] and it is probably much less, and it is widely believed that the amount of mental illness depends on the stress of everyday life.

The character of the G.P.'s work has changed considerably in recent years. It has been profoundly modified by two factors, namely, the great advances in medicine and the introduction of the National Health Service. The former have reduced considerably the incidence of many major disorders, but not of mental illnesses, which therefore are relatively higher. This trend has been particularly marked with children's illness, and as a result paediatricians are looking for fresh outlets for their activities. A suggestion has been made[5] that they should extend their range to include child psychiatry. This proposal has met with acid comments from some psychiatrists, but it has merit in so far as it would help to break down barriers between psychiatry and the rest of medicine.

The National Health Service has almost certainly caused an increase in the amount of psychiatric illness with which a G.P. has to deal. The work of Hollingshead and Redlich[6] in America suggests why this may be so. They found that there is a marked variation in the incidence and in the severity of mental illness between the social

classes. They also found that the proportion of the population undergoing treatment for mental illness was three times greater at the bottom of the social scale than at the top. There was, moreover, a striking difference in the character as well as the amount of illness between the classes.

They found that at the top of the social scale 65 per cent of mental illness was neurotic and 35 per cent psychotic, while at the bottom of the scale only 10 per cent was neurotic and 90 per cent psychotic.

These authors commented on the much greater tolerance of mental illness at the bottom of the social scale than at the top. They suggested that there may be a lot of untreated mental illness at the bottom but very little at the top. In Britain, because of the existence of the National Health Service, this may well not be so.

In America, most psychiatric treatment, apart from custodial care, has to be paid for privately, but in Britain the National Health Service has swept aside the barrier of a fee between patient and doctor. It seems that in doing so it has released on to G.P.s a flood of major and minor mental illnesses, particularly in the lower social classes, that previously doctors were not called upon to treat.

G.P.s, unlike paediatricians, do not see psychiatry as a desirable field to replace lost organic illness. Instead they have a flood of psychiatric illness thrust upon them whether they like it or not, and mostly they do not.

The National Health Service has greatly increased the G.P.'s burden of psychiatric illness, but has left him to devise ways of treating it himself. In contrast, G.P.s are provided with efficient help in dealing with major organic illness. For instance, an acute abdominal emergency presents no problem, for once the G.P. is within reach of a telephone the National Health Service will ensure that the patient receives the skilled treatment of which he is in need. It is quite another matter if the emergency case that the G.P. has been called to see proves to be a patient in an acute anxiety state who believes he is about to die. The National Health Service gives the G.P. undivided responsibility for dealing with the case, although it is most unlikely that in his medical training he will ever have been taught how to handle it. The G.P. is required to attend his psychiatric patients, in their homes if they demand it, at any time of the day or night that they ask for his services. No doctors anywhere have previously shouldered such responsibility.

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1. Pemberton, J., 1949, *British Medical Journal*, 1, 306.
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Postgraduate Education in Psychiatry for the General Practitioner

By T. P. REES, O.B.E., M.D., F.R.C.P., D.P.M.

The improvement in the public health during the past century has resulted in an increased expectation of life. Today the public have gone a step further, and they are showing an increasing interest not only in the quantity of life available to each person but also in the quality of that life. Certainly what prevents many from enjoying a full and productive life within the affluent society in which we live is mental or emotional disorders of some kind.

It would seem that it is only when people are free from want and from the scourge of frequently recurring epidemics or infectious diseases, often fatal as well as incapacitating, that they can afford to turn their attention to disorders of the mind. As the pattern of disease and the economic circumstances of his patients change, so does the nature of the work of the general practitioner.

More People Consult their G.P.s

The increase in the quantity of life available to all means that more general patients than ever before are suffering from the disabilities of old age, and the demand for a better quality of life has resulted in an increasing number of patients, who show no sign of or do not suffer from any organic disease, seeking the help of their doctor. It does not help such patients to be told that there is nothing the matter with them physically. They know they are ill, and they know they are miserable, and they know they are in need of treatment. One general practitioner attending a recent Course for General Practitioners in psychiatry estimated that 60 per cent of the patients who consulted him came into this category, whereas his medical training had been directed almost entirely towards equipping him to treat the other 40 per cent. Other practitioners give the incidence of mental disorders in their practice as being as low as 10 per cent. The general opinion seems to be around 30 per cent.

Demand for Extra Instruction

Today there is a great demand for extra instruction in psychiatry coming from undergraduates as well as from graduates. Rapid strides have been made in improving facilities for undergraduate education in psychiatry in recent years. Last year new chairs of psychiatry were instituted at Birmingham University, St. George's and the Middlesex Hospital Medical Schools, and the time may not be far distant when every Medical School will have its full time Professor of Psychiatry.

For the post-graduate, especially those who have been qualified for many years the need for some form of instruction in modern psychiatry has become acute. But it is impracticable to provide practitioners with lengthy courses such as are given to today's undergraduates. There are, however, various means by which the family doctor in active practice can receive post-graduate instruction in psychiatry without interfering unduly with his work.

These include :

1. Discussion of his own case over a domiciliary visit with the psychiatrist of his choice. This is not only a very practical but also a very effective method of instruction. In the same way much can be learned by the psychiatrist's report on patients he has referred to an Out-Patient Clinic, or on his patients discharged from Hospital.

2. For many years some mental hospitals have invited local practitioners to attend their weekly case conferences. These can be particularly instructive when the practitioner's own case is being presented after a complete investigation. The drawback lies in the fact that many hospitals are too far away to let the practitioner attend regularly.

3. Attendance at clinical meetings which take place from time to time at most mental hospitals.

4. Joining in discussion groups when his problem patients can be discussed with other practitioners and with a psychiatrist. Such groups have proved very successful in London and other towns such as Manchester, Leeds and Portsmouth.

5. Joining a group for listening and discussion of tape recordings, which can be supplied by the College of General Practitioners or by the British Medical Association. These can be invaluable in small country towns and remote centres where it is difficult to obtain a speaker. There are also a number of films available for the same purpose.

6. Attendance at B.M.A. meetings. Most Divisions arrange for one of the talks during each session to be on a psychiatric subject likely to be of interest to general practitioners.

7. Some general hospitals employ general practitioners on a part-time basis as clinical assistants in the Psychiatric Department.

8. An increasing number of mental hospitals employ general practitioners as medical officers on a part-time basis to look after their long term patients and to carry out emergency duties during the week-end.

9. Attendance at seminars for general practitioners where the emphasis is on the doctor-patient relationship and on the general practitioner as a psychotherapist. Practitioners attend weekly for two or three years or even longer. Very successful seminars on these

lines have been instituted by Balint at the Tavistock Clinic and by Main at the Cassel Hospital.

10. Courses of varying content and duration are run at various Centres, including amongst many others the Maudsley Hospital, Sheffield University, the Royal Free Hospital and at Ipswich in connection with the General Hospital and Child Guidance Clinic. Some are general and include a psychiatric section. Others are solely psychiatric for a day, a week-end, or a session a week for eight weeks or longer.

11. Whilst in some parts of England and Wales the facilities for the post-graduate education of the medical practitioner are good, there are many others where no such opportunities exist, and bearing this in mind the N.A.M.H. decided in 1959 to fill the breach by holding a residential week-end course on "Psychiatry for the General Practitioner". Since that time four such courses have taken place and the fifth is planned for May 1962.

Questions and Discussion

Each course consists of eight short lectures followed by ample time for questions and for general discussion. The aim is to give the doctors some insight into some of the following: The technique of the psychiatric interview, the diagnosis of the various forms of mental disorder; the scope of psychotherapy, drug therapy and other forms of treatment; the psychiatric problems of childhood, adolescence, marriage, and old age; how to deal with psychiatric emergencies; the organisation of the mental health services; the rôle of the general practitioner in the treatment of the mentally ill, and the indications for referral to a specialist.

The courses, which have been attended by general practitioners from all parts of England and Wales, are not intended to be comprehensive, but rather to act as an appetiser in the hope that practitioners will be stimulated to continue their interest in psychiatry after returning to their practices, and demand the setting up of similar courses within easy reach of their own homes.

At the 1961 N.A.M.H. Annual General Meeting
Dr. Russell Barton lectured on

Social Clubs for the Mentally Disordered

Below we reproduce a report of his address, reprinted by kind permission of the editor, from the *Hospital and Social Services Journal* of December 8th, 1961.

"Social Clubs for the Mentally Disordered—A Job for the Professional and the Amateur?" was the subject considered at a session of the annual general meeting of the National Association for Mental Health, under the chairmanship of Dr. Wilfred G. Harding, Divisional Medical Officer, London County Council.

Dr. Russell Barton, Physician Superintendent of Severalls Hospital, Colchester, and widely remembered for his recent study on institutional neurosis, read a paper which was based largely on a questionnaire circulated to Medical Superintendents of psychiatric hospitals and hospitals for mentally subnormal patients and County Medical Officers of Health. There was a 90 per cent response; unfortunately Dr. Barton had not found it possible to circulate Medical Officers of Health of county boroughs and certain voluntary organisations which run clubs, but hopes to do so later in a more comprehensive inquiry.

The 109 replies included reports on 95 social clubs, 31 located in hospital and 64 located outside. The first club was started by Drs. Bierer and Haldane, of Runwell Hospital, 20 years ago. About 15 have been running for more than 10 years. Half the social clubs were started in the last few years.

Facts about the Clubs

Clubs meet from as little as monthly for one hour during the winter to two hours six times weekly. The majority meet for two hours once a week.

Premises used vary from rented houses, rooms and halls, Red Cross centres, schools, British Legion headquarters and Nissen huts to Victorian houses, children's nurseries, child welfare clinics and day centres for mentally subnormal patients.

Average attendances range from 10-20 in 31 clubs, 20-30 in 21 clubs, 30-40 in 12 clubs and over 40 patients in 18 clubs. Transport is provided by voluntary workers in 27 clubs, public transport in 24 clubs, hospital transport in 14 clubs; none is provided in 10 clubs.

Being a patient or ex-patient under psychiatric care, usually with socially acceptable behaviour and referred by a doctor, social worker or mental welfare officer are the usual requirements of

membership. About one-fifth of the social clubs are principally for the mentally subnormal. Many clubs accept both mentally ill and subnormal patients, although two stipulated that patients must be reasonably intelligent.

The purpose and function of the clubs was generally stated in terms such as:

To enable the socially diffident to find companionship with others and thus to restore confidence; to provide a training in social behaviour and to rehabilitate; to follow up patients, so that signs of relapse could be noticed earlier than if out-patient attendance was the only contact and "to educate patients factually and to widen their interests generally".

Professional Staff's Part

Opinions as to whether a club could be run entirely without professional staff varied considerably:

Nineteen thought that they could, but 76 were emphatic that they could not, should not or were unlikely to run successfully unless professional staff were in regular attendance. The emphasis was usually on someone with some psychiatric training and experence; not necessarily a psychiatrist, but possibly a psychiatric social worker, a nurse trained in psychiatric disorders, or an occupational therapist. Others did not stress the need for such training but emphasised the need for continuity of organisation and administration.

It was generally agreed that patients should have as large a say as possible in the affairs of their club, but that it was essential to have one or two professional workers unobtrusively in the background to keep the club running when it looked like petering out and participating where cliques of patients had developed which tended to exclude newcomers from benefits of the club.

Disadvantages were mentioned in 30 questionnaires; 11 said there were none.

Difficulties mentioned related to dominant members who were prejudiced or bigoted and could not be guided; problems arising from "amateur psychotherapy", formation of cliques tending to discourage newcomers and the very existence of the club emphasising the isolation of such patients from the community.

The Rôle of Clubs

In Dr. Russell Barton's view social clubs for the mentally disordered can play several important rôles. Patients in hospital are given a purpose to improve their appearance; other patients watching them go off realise that prospects of life outside hospital are not so remote and out of reach. Clubs afford group activity for

patients in the community, friendship and other experiences otherwise denied them because of diffidence and shyness and may improve their capacity for social adjustment and self-respect. Participation in club committees encourages a sense of responsibility and fosters initiative. Attendance at talks, brains trusts, music sessions and at club visits to other clubs and places may widen interests and appreciation generally.

The latter seems an especially valuable rôle of social clubs for the subnormal, which should probably have a separate identity from those for the mentally ill. On the one hand clubs help prepare for emergence into the pattern of normal social life. On the other hand they can offer relief to patients' relatives and probably have some favourable effect on the attitudes of the latter.

Attention to practical issues, such as ensuring that patients know the whereabouts of the club, how to get there and organising for them to join in twos, if possible by collecting them by car for the first few visits, seems important.

The ideal club would be a social transit camp, en route to normal groups such as Women's Institutes, Church clubs and evening classes. In practice, it proves difficult, however, to achieve this—some continuity of membership seems essential.

Clubs can apparently be run successfully without professionally skilled help, but this wastes valuable opportunities of liaison, and representatives of hospital and local authority should probably usually be present. Whether control of a club should be the reward taken by those energetic enough to form and maintain it, is dubious. Social clubs cannot run without voluntary helpers, but it would seem pretty hard on patients if an enthusiastic amateur decides to use them as a first step in acquiring a knowledge of psychotherapy.

Personal Relationships

Undue curiosity is often resented by patients who know only too well the meaning of speculative glances and overhoneyed concern. Pregnancies have occurred as a result of friendships made at social clubs and so have marriages, but such things tend to occur when men and women come together in the best of clubs (other than the Darby and Joan variety!) and can be played up by critics or played down by enthusiasts according to their skill.

It is not easy to provide help to a person without creating dependence; to provide affection without arousing sexual appetite; to be concerned and sympathetic without stimulating intense personal interest and the possessiveness and jealousy that so often follow. Both professional and amateur may make some of these mistakes during the necessarily prolonged formative stages of a club. In view of the fact that professional workers with their training and responsibility are somewhat less likely to err than amateurs

they should play a leading rôle in social clubs for the mentally disordered if the maximum benefit is to be achieved.

Dr. Russell Barton recorded his thanks to Miss Marie Joyce and Mr. Frederick Glen, psychologists at Severalls Hospital for their invaluable assistance in analysing the replies and for producing the paper. This was followed by a lively discussion to which doctors, social workers, patients, sociologists and voluntary workers contributed, largely on the basis of their personal experiences. There was no disagreement with Dr. Russell Barton's view that whilst voluntary workers could and must have an important function in the running of social clubs for the mentally disordered, it was essential that professional workers in the mental health field must take a live interest, if clubs are to succeed and members to derive optimum benefit.

A First Visit to Nigeria

By ROBINA S. ADDIS

In November 1961 Miss Robina S. Addis and Lady Norman spent three weeks in Nigeria and attended the first Pan African Psychiatric Conference, held in Abeokuta. This article tells of their experiences.

From a chill grey day in London to be transported overnight to tropical heat and brilliant colours in Nigeria is enough to take one's breath away. During the three weeks of our stay we never lost that sense of wonder and strange beauty.

At the invitation of Dr. Lambo, who made a memorable contribution to the N.A.M.H. Annual Conference in 1960, Lady Norman and I flew out to attend the first Pan African Psychiatric Conference. This was held at Abeokuta, Western Nigeria, in November 1961. There was a party of nine from Great Britain and Sir Aubrey and Lady Lewis, Sir Russell Brain, Dr. Peter Scott, Dr. Carothers and myself gave papers and Dr. J. R. Rees of the W.F.M.H. also spoke.

Developing Psychiatric Services

From the opening by Dr. Majekedunmi, Federal Minister of Health and himself a distinguished gynaecologist, the keynote of the Conference was Africa—how could psychiatric services be developed in Africa and in what way would they be changed by being applied in Africa? While welcoming the best the scientifically developed countries can offer, and being prepared to give the time and effort for training of the highest standards, again and again the same note was struck—a call to remember local history and custom and way of life. Much of what we saw confirmed the elements of richness of experience, of security of life in a clan and the law and order of tradition. Complex, frail in the face of change this experience may be, but making sense to many simple people.

The University town of Ibadan with its magnificent modern teaching hospital, was near enough at hand for its disinguished staff to contribute to the Conference and for the conference members to spend a day there. We paid our respects to the Western Region High Commissioner and to the Minister of Health, Dr. Osentukun. Lady Norman was received by the acting Premier and on another occasion in Lagos, by the Federal Prime Minister Sir Abubakar Tafawa Balewa, a remarkable man indeed.

The Conference itself was held at Aro Hospital, which Dr. Lambo has transformed into a pleasant open hospital and where the hundred conference members were made welcome and given their meals. We could only guess at the efficiency and good will of the staff which made this possible, keeping up the high standard of care of the 200 patients and the busy out-patients' department as well as running a training school for nurses. Dr. Asuni, the Deputy Superintendent, the Matron and Chief Male Nurses all became personal friends of ours.

It was exciting to find that there are more patients looked after outside the Hospital than in, and there are some 300 boarded out in the nearby villages. We visited, on foot, the Aro hamlet at the gates of the Hospital and saw the patients, each with an attendant relative who stays with him, in the care of the village hosts. The Elders received us with dignity and showed their interest in the scheme, not only by active participation throughout the year, but by coming to Lagos to hear Lady Norman speak.

Initiating Research

Work in the community is also being used for research and a joint study has been undertaken by Aro Hospital and Cornell University. Professor Leighton and his wife, Dr. Leighton, were there to describe the scheme and he showed us an excellent colour film which we hope to procure for London. All the inhabitants of the remote agricultural village are being examined by the psychiatric team, and records will be kept over the years which will give a picture of the incidence and type of disease or handicap.

We heard that the traditions of Africa required that when a patient was treated, his family must be treated as well and this we saw in practice. It is possible to keep even very sick patients boarded out because of the support of the relatives and villagers. Daily visits of doctors and nurses, the fact that the Day Hospital and Occupational Therapy are available and, if necessary, beds in the hospital all provide safeguards for the scheme. Where it is not feasible to keep a patient in open conditions and for the criminal patients there is the closed hospital of Lantoro. This we also visited and were interested to see how the old asylum is being transformed. Already the women's wards are staffed by nurses from Aro Hospital, its

occupational therapist. Mr. Ina, held sessions there and it is hoped that ties will be made still closer with Aro. The setting as much as the Conference itself, was thus stimulating and encouraging.

Lady Norman and I were able to spend some days in the Eastern Region and flew to Enugu, where we had the privilege of being the guests of the Chief Justice, Sir Louis and Lady Mbanefo. Here we found ourselves in a countryside of rolling hills where coal mines had brought development. Besides visiting technical training colleges and an Approved School, we saw the new University at Nsukka. Eighteen months ago the land was bush and now fine modern buildings house eight hundred students and the teaching facilities are expanding while attractive homes are being built for the staff. Many of our ancient seats of learning might envy the amenities and respect the initiative and drive which has built this University in miraculously short time.

Creating the Best

Back in Lagos we visited new hospitals which again showed this rush to create the best. It is seen not so much in offices and homes, though these also are going up in moderation, but Government buildings and places for education and for medical services. Is it because Independence is but a year old that these buildings are inspired with the spirit of the new and aim towards high function and beauty? We saw new churches which embody this sense of dedication. It is a rapid change but built on an appreciation of values which can also be traced in more subtle ways.

Buildings in themselves, of course, cannot achieve services, but the glimpses we had of welfare work, for instance, showed that the basis is there for social services to be developed. Missions have led the way in education and medical care, the values are accepted and now the new Government takes on its responsibilities. Social Welfare which comes under the Ministry of Labour in Lagos, is organised on a large scale and the Social Workers include some with training. Work for the blind, both statutory and voluntary, begins to make its mark and the Ministry of Education has built a school for the deaf as well as for the blind. Not only Welfare Officers but traditional methods of mutual help provide services in the country and so in spite of the lack of general welfare arrangement as we know them, Nigerians can say you seldom find an orphan or a waif and there is little problem of old age because the families take care of old people.

This is not to say that there is not much crying out to be done. Water supply, sanitation, adequate nutrition are sadly lacking throughout the country and there are social abuses of the weak as well as widespread preventable disease. But as you see the people walking with a carriage that is proud, even though born of carrying

loads on the head, as you learn of the strength of family ties which take on the burden of education or care for its weaker members, you wonder if the "patterns of tribal society" are in many ways not more socially effective than our own.

Making the Public Aware

In considering the psychiatric services and work for mental health, it is realised that public awareness of the problems must be created. Dr. Lambo had seen that a Nigerian N.A.M.H. could serve this purpose and Lady Norman's talks on the work of voluntary bodies given to public meetings at Lagos and Enugu and her two successful appearances on television in the Western and Eastern regions were quickly followed by an inaugural meeting. Never has a committee worked so fast and so effectively and in an hour or two the whole structure of the Association had been worked out. The interest of leading personalities had been won and with the support of Lady Ademola and Lady Mbanefo and the dynamic secretaryship of Dr. Lambo, the new Association seemed certain of success.

Before the Conference had ended an Association of Psychiatrists in Africa had been formed and the enthusiasm of those working both in Nigeria and the other states represented: Kenya, Uganda, Mauritius, Sudan and South Africa promised well for its future. Others who had worked for years in Africa, such as Dr. Carothers and Dr. Margetts, had been drawn back from England and Canada to bring to the Conference the benefit of their experience in a land they had grown to love. With so few psychiatrists in Africa and many working in great isolation, an Association which could give them mutual support and serve for the exchange of information would have a particular value.

The Nigerian climate and the history of its people must affect and transform whatever services, psychiatric or social that are introduced. In no context is this more evident than in the field of psychiatric social work. This function depends on understanding not only the development of the individual and his family and community relationships, but must be rooted in the setting in which he lives. In our brief visit to the country we were constantly challenged by new facts which cut across our assumptions of social patterns and we realised that many principles would have to be revalued if a social service was to be grafted on to the pattern which had been evolved through history and in that place and climate. Perhaps too much may be made of differences and the danger of imposing a system which crushes the living reality because we do not recognise it. The President of a women's club, which entertained us in Abeokuta, said in Yoruba: "Our skins are different but our hearts are the same".

A Chair of Psychiatry is to be established at Ibadan in 1962 and this will give a lead and may include training for Psychiatric

Social Workers. Great opportunities await the right people who will help with this enterprise and they will have the satisfaction of serving a country which aims for the best services and miraculously surmounts obstacles. The dreams of today are made realities tomorrow.

Nigeria has been described as "a country in a hurry" and the chief impression is one of immense vitality and enjoyment, amazingly rapid development and eager hopes against a background of colour, ancient wisdom and great friendliness. Population problems, need for water supplies and improved living conditions, difficulties of the balance of economics, problems of standards of education apart from any political questions face the country with an enormous challenge. The need for discipline and hard work is acknowledged. With sons such as Dr. Lambo to lead the way and with co-operation on all sides, Nigeria can bring hope to Africa.

A Visit to the U.S.S.R. and Poland—Part II

By DORA McCLELLAN

In Part I of this article, published in the Autumn 1961 issue of *Mental Health*, Miss McClellan wrote of the Russian part of her tour in June last year as a member of a delegation from the Women's Group on Public Welfare. In Part II she is reporting on her visit to Poland, where her tour began in Warsaw.

Soon after my arrival in Warsaw I called on Dr. Gnat of the Ministry of Health who had previously visited the N.A.M.H. in London. With him was Dr. Malewski who interpreted. Dr. Malewski is himself interested in group therapy and has introduced this in his clinic in Warsaw, having spent a year working in Prague under a Czech doctor who studied at the Tavistock.

We discussed the care of the mentally subnormal. Dr. Gnat said they agreed in principle with the training of the severely subnormal but as yet they have not got the trained instructors. They are still having difficulty in providing facilities for normal children.

Subnormal children are first seen at an outpatient centre for diagnosis. If they are severely subnormal they usually go to institutions owing to the lack of facilities at home. Parents may, however, keep the child at home if they wish and then doctors and social workers give advice on upbringing.

Dr. Gnat said they were very interested in the problems of rehabilitation of the mentally sick and asked for information about work in the U.K. Public prejudice is said to be a barrier also and a shortage of social workers.

Dr. Gnat then very kindly planned a programme for me.

This unit takes healthy children and children with behaviour disorders or psychoses. They have a premature baby unit and a unit which takes for investigation children for adoption.

Dr. Bizlicka has been specially interested in the study of deprived children and has written up a series of cases of maternal deprivation. She has read Dr. Bowlby's work and would like contact with the Tavistock Clinic.

Dr. Bizlicka said that at her unit they have a child guidance team of three. They make a point of contact with the family. Father, mother and *grandmother* are asked to attend with the child. As most women in Poland work, it is often the grandmother who looks after the child and they feel it important to get her co-operation. They are starting to admit mothers with their children and are the only hospital to do so.

There seemed to be a high staff ratio with experienced and well trained nurses.

With Dr. Malewski I visited a dispensary which deals with mental health problems in children and adolescents, from birth to the age of seventeen or in the case of girls sometimes up to eighteen years of age.

The Director is a Dr. Szymanska, an elderly woman who was at the Brussels Child Guidance Seminar. She speaks excellent French.

There are 13 doctors at the dispensary and 13 psychologists plus secretaries and nursing staff. There are no social workers and Dr. Szymanska deplores this as she says much of the doctors' time is taken up with work which could be done by a social worker. Patients are referred to the clinic by a doctor, either the school doctor or a general practitioner. They are supposed to come with a note of introduction and a diagnosis, but very often the clinic is confronted with a child, an incoherent mother and merely a visiting card from the G.P.

They try to give a child guidance service and a good deal of time is spent with relatives. They arrange immediate admission for children suffering from chorea, major epilepsy or psychotic children. Others are treated as outpatients.

Case histories are taken by the psychologists who also do any necessary testing. Dr. Szymanska said that there was as yet insufficient provision for E.S.N. children and very little provision for the severely subnormal except in institutions. She spoke of the great difficulties with which they are faced in Poland, as the country has had to build up all its services from scratch since the war.

There was not enough time to see much of the Dispensary but we went round some of the rooms and met some of the staff.

Our next visit, Dr. Szymanska kindly acting as guide for the day, was to the college where teachers of the handicapped are trained. This normally is a five-year course and the curriculum is very extensive. The college also provides refresher courses which teachers can attend in the summer vacation. Teachers are trained

to deal with all kinds of handicapped children, deaf, blind, and physically handicapped. They agree there is a great need to train instructors for the mentally subnormal, but they have not yet tackled this. They were very interested to hear of the N.A.M.H. Diploma Course, but thought that one year would be too short a training. I pointed out that in England we thought it far from ideal, but it had bridged a gap and brought us a long way, and I spoke of the present work of the Scott Committee. They would like to hear more of our work.

From the teacher training college we went on about forty miles out of Warsaw to the Couvent des Soeurs Samaritaines at Negów. Dr. Szymanska said that this was a very poor convent which took severely subnormal boys. The Government allow 15 zlotys a day for each child (about 5s). The convent has to maintain itself. It has considerable grounds which are worked by the nuns who grow vegetables and fruit.

We arrived quite unexpectedly and at first found it difficult to announce ourselves as part of the convent was being repaired and two workmen were trying to see-saw an enormous plank in through a window and would pay no attention to our indignant driver! Finally we were directed to the right door and were welcomed by the Mother Superior. The convent was very poor; they have only recently been able to install running water—but it was spotlessly clean. We went into a ward where there were some very severe cases, hydrocephalics and microcephalics, all cot cases. I have never seen such a standard of cleanliness; there was not a suspicion of smell.

As far as possible the higher grade imbeciles are taught to do simple tasks in the garden, etc., and we were told that one of the boys had learnt to drive a car and had obtained his driving licence! This was considered very exceptional. Children from this home go ultimately to the big mental deficiency institutions as there is no other provision for them.

Visiting the Blind

We later visited the Laski Institute for the Blind in Warsaw. This again is a convent and takes children and adults who are in need of training. They have many patients with multiple handicaps, for example the deaf-blind, and also a group of blind "feeble-minded". They have a high standard of woodwork, weaving and ironwork.

After a most absorbing couple of hours, we sat and talked over tea with Mother Katarzyna who is in charge of much of the training work. She is a wonderful woman with a great store of energy and wisdom. Her interest reaches out beyond her work for the

blind. She had heard, for example, that in England we were experimenting with the rehabilitation of the mentally sick. Just what were we doing—and how?

During my brief stay in Poland, this was the keynote of most conversations. There is the keenest interest in what is happening elsewhere in fields of work related to their own. I am sure that one of the most useful things we can do, is to help them wherever possible with factual information, and it is encouraging to know that interchange of visits between people in our two countries seems to be becoming easier.

Parliament, Press and Broadcasting

PARLIAMENT

The Sowle Case, 23rd October, 1961

In answer to a question by Mr. Dodds on Ronald Derek Sowle the Minister of Health cited the Conclusions of the Report of the Board of Enquiry consisting of Mr. H. E. Park, Q.C. (Chairman), Dr. Desmond Curran, C.B.E., F.R.C.P. and Mr. J. R. Mackie, C.M.G., B.Sc. as follows:

> "In the course of our enquiry we received much evidence, both oral and written, to which we have not referred in this report. We have, however, investigated with care all the available evidence on all the incidents in Sowle's life which could possibly give rise to the view that he was in April 1961 a potential danger to the public. We have summarised that evidence in the course of this report. The only incident which might reasonably have given rise to the suspicion that Sowle might be a potential danger is the incident of alleged knife brandishing in September, 1953, discussed in paragraph 8 of this report. But that incident and the other minor incidents of misconduct to which we have referred must be considered against the overwhelming body of evidence which established clearly that, since 1955, Sowle was well-behaved and not given to any kind of violence nor subject even to outbursts of temper. While out on parole and while living at Berwick Lodge, Sowle had mixed freely with the public and, up to the 27th April, 1961, had proved himself to be someone who could be trusted to behave properly while outside the hospital. Our investigation shows, and it is our opinion, that there was no foreseeable risk that Sowle would be likely to be a source of danger to anyone.
>
> Our findings are as follows:
>
> 1. Dr. Walker was right in his opinion that Sowle on the 24th April, 1961, was suffering from subnormality and that that mental disorder was not of a nature or degree which warranted Sowle's detention in a hospital for medical treatment;
>
> 2. Dr. Walker, in recording this opinion pursuant to paragraph 7 (3) of the Sixth Schedule of the Mental Health Act, 1959, correctly followed not only the provisions of the Act itself but also the recommendations of the Royal Commission and of the Ministry of Health.
>
> 3. The circumstances in which Sowle was re-classified as an informal patient on the 24th April, 1961, have no relevance whatsoever to the commission of the crime of which he was found guilty."

24th November, 1961

The Health Visitors and Social Workers Training Bill was debated on the Second Reading.

In reply to Questions on the Mental Health Review Tribunals

The Minister of Health gave the numbers of applications to Mental Health Review Tribunals in each region up to 30th September, 1961. Total applications for the whole country 545; 58 discharges granted (*Hansard,* 23rd October, 1961).

The Home Secretary (23rd October, 1961) stated that the appropriate Mental Health Review Tribunal had recommended the discharge of six patients from Broadmoor—in three cases he had accepted the Tribunal's advice, one case was still under consideration and in two cases he had not accepted the advice. No recommendations for discharge from Rampton or Moss Side had been made.

The Minister of Health stated that at 6th November, 154 applications had been made to Tribunals on behalf of patients in Rampton and 98 on behalf of patients in Moss Side (*Hansard,* 18th November, 1961).

Hospital Orders

The Home Secretary, on being asked what considerations he takes into account in deciding whether to accept or reject the advice of a Mental Health Review Tribunal that a patient subject to an order restricting discharge or kept in custody during Her Majesty's pleasure should be discharged, replied that such advice was considered in the light of all material available to him about the risk of danger to the public if the patient were released (*Hansard,* 9th November, 1961).

The Home Secretary stated that during the eight months from 1st November, 1960 to 30th June, 1961, 563 Hospital Orders without restriction had been made under Section 60, under which two patients were admitted to Broadmoor, eight to Rampton and six to Moss Side. Eighty-five Hospital Orders with restrictions had been made under Sections 60 and 65. Under them three patients had been admitted to Broadmoor, 21 to Rampton and two to Moss Side. (*Hansard,* 23rd October, 1961.)

Mr. K. Robinson (12th December, 1961) asked the Minister of Health if he was aware that several cases have arisen where a hospital has agreed to accept a patient suffering from mental disorder on a hospital order made under Section 60 of the Mental Health Act, and on admission it was found a further order restricting discharge under Section 65 had been made by the court, and if he would arrange for hospitals to be informed, when they were asked in advance to accept such a patient, that a Section 65 order was in contemplation and to be authorised to refuse admission when a patient arrived under such an order without prior notice. The Minister replied that the decision whether to make a hospital order, with or without discharge, rests entirely with the court, whose conclusion cannot be known when a patient arrives under such an order without prior notice.

Mentally Ill Children

Following a question from Mr. Dodds about the case of a ten year old girl who, while awaiting admission to a school for maladjusted children, was for seven months the only child in a mental hospital with 1,200 adults, the Minister of Health stated that at 1st April, 1961, there were 202 mentally ill children under 12 in psychiatric beds and about 260 places in wards for mentally disturbed children under 13.

RADIO AND TELEVISION

Below we summarise the main radio and television programmes during the last part of 1961, which were of particular interest to all concerned about mental health.

30th October: B.B.C. Home Service. "Indian Summer" dealt with problems of retirement.

30th October: B.B.C. Network Three. In "Parents and Children" series the programme discussed how children differ.

12th November: B.B.C. Home Service. In "Home for the Day", an item on Loneliness—personal isolation in 1961.

12th November: B.B.C. Home Service. "A Cry for Help?"—some aspects of the problem of suicide.

13th November: Associated Television. The programme in the "Proba-Officer" series showed the work of Prison Hostels, which are run by the Prison Commissioners in conjunction with the Ministry of Labour.

14th November: B.B.C. Home Service. In the series "The Silver Lining", a consultant psychiatrist talked about the meaning of dreams.

27th November: B.B.C. Light Programme: In "Woman's Hour", a discussion on prostitution.

28th November: B.B.C. Home Service. In "Silver Lining", the consultant psychiatrist again talked to listeners about dreams.

2nd December: B.B.C. Television. A repeat of the programme "Another Child's Poison", dealing with research into Phenylketonurea.

4th December: B.B.C. Light Programme. In "Woman's Hour", an item on "Women and Crime", in which the types of crime committed by women in this country and in the United States were discussed.

7th December: B.B.C. Television. "Perspective" was devoted to the courage of people in calamity.

8th December: Associated Rediffusion. In the series "The Warning Voice"—the subject was lonely old people.

14th December: B.B.C. Television. "Loneliness" was the subject of the programme in the series "Perspective". A team answered questions and suggested how some of the barriers can be broken down.

17th December: B.B.C. Television. In "Meeting Point", John Freeman asked a panel of speakers to answer the question "should a person be told when he or she is going to die?"

1st January onwards: B.B.C. Network Three. "Growing Up in the 1960s". A series for listeners with a professional or personal interest in adolescents. First programme "What is Adolescence?"

PRESS

As well as a good press on the N.A.M.H.'s pamphlet "Not in My Perfect Mind", major items of interest at the end of 1961 included the following:

29th October and 5th November: Two articles in the *Sunday Telegraph* by Allen Andrews on "Curing Sick Minds the Modern Way"

describing new trends and attitudes. The need for adequate trained staff was stressed.

October: The conference on Rehabilitation, arranged in Harrogate by the northern branch, attracted attention in the northern press. The need for work for patients was stressed, and the importance of good staff relations affirmed. The problem of rehabilitation of patients has come up frequently during the year—in addition to the N.A.M.H. conferences on the subject, *Rotary* carried an article and *Industrial Welfare* will publish one in February.

November: *The Observer* carried a series of articles by Dr. Abraham Marcus under the general title "What's Wrong with the Health Service". Dr. Marcus surveyed the National Health Service since its inception in 1948, analysed what he considered to be its faults and made recommendations for its improvement. The series provoked lively correspondence.

November: There was wide press coverage following the report of the Home Office Research Unit entitled "Murder".

Throughout 1961 attention was focused on the increase in adult and juvenile crime. In November the Home Secretary called a conference to help combat juvenile crime. Delegates from interested organisations attended and N.A.M.H. was represented by Lord Feversham and Miss Applebey.

5th December: *The Guardian* carried an article by John Maddox called "Human Inheritance", dealing with research into mongolism.

11th December: The publication of the broadsheet on "Mental Subnormality and Community Care" by P. E. P. was noted in the national press. The report is part of a three-year study of the Community Mental Health Services.

News and Notes

Ministry of Health Publishes Part II of its Report for 1960

In Part II of the Minstry of Health Report for 1960 on mental illness, the Chief Medical Officer referred particularly to the two trends in hospital admissions, pointing out that the number of patients who had been in hospital for two years and more was diminishing and the length of stay in hospital for newly-admitted patients was shortening.

He further commented that whatever happened in the provision of hospital buildings it was clear that medical and nursing services would need expansion. More psychiatry was needed, though in fewer buildings. The community mental health service would have an increasingly important part to play in the prevention of mental disorder, and the rehabilitation of patients recovering from a breakdown. The value of the use of work therapy was especially stressed.

Mention is made in the *Report* of the "degree of tolerance that can be expected of the public in general and families in particular for precariously adjusted and eccentric individuals". The *Report* comments: "Any answer to this question must be qualified by the amount and variety of support that the social services are able to give such persons. In some cases regular work is all that is needed, in others the more specialised help of the family doctor or social worker is required."

The right of the public to protection against persons whose mental disorder makes them potentially dangerous is stated, but the *Report* points out firmly: "The benefits that have followed the relaxation of the traditional custodial discipline in the mental hospitals are beyond question. Among them is a change in the manifestations of mental illness: the 'raving lunatic' is now a rarity, patients are not afraid of coming into an open hospital, and acts of violence and bad behaviour in hospital have greatly diminished."

Provision of Hospital Beds

The *Report* estimates that "half the projected total of 1.8 beds per 1,000 of the population will eventually be needed for long-stay patients. This figure of about 0.9 per thousand derives from the follow-up of patients admitted to mental hospitals in 1956. It includes the 21 per cent of old people, many of whom might be treated elsewhere. It is to be hoped that expansion of provision for old people both in the general hospital and local authority services will substantially reduce the number requiring psychiatric care".

On beds for short stay patients, the *Report* comments that their number is largely governed by the length of stay of the patients who occupy them, and that it is not really possible to estimate how long the average duration of stay will become in the next few years.

On provision of hospital beds for the subnormal and severely subnormal, the *Report* feels the need "should be governed to some extent by the provisions made for these people in the community". It points out that the

number of high-grade subnormal patients in hospital continues to fall and that of the lower grade and severely subnormal to rise, commenting that these trends were due "on the one hand to the willingness of society to accept and provide employment for people who in less prosperous times would be unable to fend for themselves, and on the other to medical advances that prolong the lives of the severely subnormal and physically handicapped and lower their mortality in infancy.

"The hope that these trends would keep pace with each other has not been realised. The additional beds provided in hospitals for the subnormal and severely subnormal in recent years has produced only a slight decrease in the waiting lists for beds in these hospitals . . . The need for more beds for this side of the hospital service seems inescapable."

It will be interesting to see whether, in the light of these latest comments on hospital bed provisions, the pronouncement by the Minister of Health at the Association's Annual Conference in March, 1961, will be borne out. Readers will recall that he prophesied a redundancy of no fewer than 75,000 hospital beds for mental illness in fifteen years' time.

Brentford Factory Helps Mentally Subnormal to go to Work

One of the most significant achievements for a severely subnormal adult is to become at least partially self-supporting. One plastics factory in Brentford has been playing a very important role in helping a small but increasing number of subnormal men and women to earn money towards their livelihood.

The experiment—the first of its kind in this country—was begun in May 1960, when six severely subnormal youths were given work in the factory under the supervision of an Assistant Supervisor/Instructor on the removal of flashing from moulded bakelite motor car accessories. The formal agreement with the firm included a paragraph limiting the tools to a file and a screwdriver, and careful thought was given in drafting the agreement to ensure that at no time should any trainee be exposed to the "dangers" of either light or heavy industrial machinery generally used in the factory.

After a few months it was apparent that the trainees could be given more complicated work and they began to use light compressed air-driven machines. With the approval of the Middlesex County Council their numbers were increased, the work was varied and they began to work side by side with the firm's employees.

Now 45 male and female trainees are at the firm under the supervision of three staff, most being brought in by coach at 9 a.m., but some arriving by foot, bicycle or public transport. They work until 5 p.m. from Monday to Friday and have a 45-minute break for lunch in the staff canteen, as well as short tea breaks in the morning and afternoon.

They regard themselves as employees of the firm, and the effect of working side by side on a variety of operations with other employees in the factory has been remarkable, the improvement in general demeanour and behaviour having to be seen to be believed.

The firm pays to the County Council the amount earned by the trainees on a piece rate basis, and the Council in turn gives to them on a monetary reward system varying amounts up to 35s. a week.

The majority of those involved have an I.Q. of less than 50, and the work they are performing had hitherto been considered beyond their capacity.

The scheme has proved that even the lowest grade of severely subnormals can be trained and encouraged to undertake useful and remunerative tasks and that the severely subnormal is no more accident-prone than the average person. A special tribute should be paid to the County Council staff of the Centre within the factory and to the ready and willing co-operation and encouragement both from the management and employees of the factory alike.

The experiment has been described by Mr. Kenneth Maplesden, Administrative Head of the Mental Health Service of Middlesex, to whom we are indebted for the information in this note, as "an inspiration to those involved in the organisation of the mental health service in the County and an example of what can be achieved with the general public understanding some of the problems of the mentally disordered".

Lady Harewood Opens Music Therapy Centre in Mental Hospital

In December the Countess of Harewood opened what is believed to be the first specially adapted centre for music therapy in a mental hospital in Great Britain. This is at the Horton Hospital, Epsom, Surrey, the centre being formed by partitioning off and adapting part of the over-large chapel.

Lady Harewood was introduced by the Chairman of Horton Hospital Management Committee, Mr. George Paines, O.B.E., F.C.I.S., who explained that: "The idea of inaugurating this music centre for patients originated in the fertile brain of Dr. Rollin, who was well supported by Dr. Watkin and the remainder of the medical staff and by every member of the Management Committee. We are also fortunate in having such an accomplished musician as Lady Forsdyke at the helm."

He continued: "I am given to understand that this hospital is the first in Great Britain to provide for its patients such treatment in a specially adapted centre, and it is hoped that the initiative shown will encourage emulation throughout the National Health Service."

Mr. Paines also took the opportunity to thank King Edward's Hospital Fund for London for a grant of £3,550 and the South-West Metropolitan Regional Hospital Board for £1,500.

In opening the centre, Lady Harewood said: "I am delighted to be here on what can for once be accurately described as 'this very special occasion' and I would like to offer my congratulations to everyone who has been concerned in the achievement of this splendid—and indeed unique—centre.

"Nobody who has read about it could have failed to be profoundly impressed by the new development of music therapy. That music is now

used scientifically in cases of mental illness, and with results that science itself recognises as being extraordinary, is undoubtedly a true advance in medical history.

"The importance of self-expression through the visual arts has long been recognised. Drawing, painting, handiwork of all sorts at least assist towards a beneficial release, and can do very much more. Music, on the other hand, in this least consciously musical of countries, has, until very recently, been regarded as something of an exotic, and has been expected by many to play a lesser part in people's lives than the other arts."

Following Lady Harewood's address and other speeches a concert was given by patients—most of whom were schizophrenics—and the music therapist.

Secondment of Child Care Officers for Training

We have read with much interest Home Office Circular No. 2/1962 dated 4th January, 1962, on the secondment of serving child care officers for training. This circular states that the Central Training Council in Child Care in pursuance of its efforts to increase the numbers of trained child care officers is considering the provision of training facilities for experienced but unqualified child care officers who are already in local authority employment.

The financial difficulties due to domestic responsibilities of such officers are recognised, and it has been pointed out that from time to time some local authorities have been prepared to second staff on full salary to undertake training and that others might be prepared to second officers on part salary, possibly at a rate sufficient to make up the grant they receive to their normal full salary. It is recognised that such a payment of part salary has previously resulted in a reduction of maintenance grant payable to the trainee by the Home Office.

The Central Training Council has now recommended that the maintenance grant assessment procedure should be revised with a view to encourage local authorities to second staff on part-salary for child care training. The Secretary of State has decided that part-salary may be disregarded henceforth in assessing the amount of grants to be awarded to seconded child care officers who were in local authority employment as such on 1st April, 1961.

The effect of this decision means that "these officers during training on a child care officer course provided in association with the Central Training Council, are eligible to be considered for the award of the maximum amount of maintenance grant, subject to the amount of grant being limited, where necessary, to such a sum as when aggregated with the net amount of part-salary (i.e. after deduction of income tax) will be equal to the net amount of salary the officer would have received had he remained in employment. For this purpose, local authorities are asked to notify the Secretary of the Central Training Council within three months of the beginning of the course of the net amount of part-salary payable to an officer seconded for training under these arrangements. Income other than part-salary paid by an employing authority will continue to be taken into account for grant assessment.

Lord Monckton Opens Centre at Tone Vale Hospital

In December, Lord Monckton, Chairman of the Mental Health National Appeal, opened Ivor House, Tower Lane, Taunton, the first of a number of social health centres planned by the Tone Vale Hospital Management Committee.

The new centre was formerly a private residence. It has been redecorated, refurnished, and extended at a cost of about £20,000 to enable day-hospital treatment to be given to patients in the Taunton and Wellington areas.

In opening Ivor House, Lord Monckton stressed the importance of getting the mentally ill into an optimistic frame of mind towards recovery, and pointed out that as many beds were occupied with patients with mental disorders as there were by all other illnesses.

He spoke of the tremendous room for research, and hoped that he would be able to look back on the foundation of Ivor House as that of a really great health centre.

Evelyn Fox Book Awards

During 1961 book awards from the Dame Evelyn Fox Memorial Fund have been made to Mr. D. J. Anderson, Mr. J. D. Gouger, Miss M. Hergett, Miss C. S. Holliday and Mr. E. E. Stephenson. These prizes are awarded each year to individuals studying for or employed in mental health service or research in memory of Dame Evelyn Fox. Applicants should be sponsored by someone who can testify that their work shows promise and that they cannot easily afford the books they need. Preference is given to those who are in training at the present time or who are planning to continue study after qualification.

Enquiries can be made and application forms obtained from: The Hon. Secretary, Dame Evelyn Fox Memorial Committee, N.A.M.H., 39 Queen Anne Street, London, W.1. *The closing date for applications for the 1962 award is May 1st.*

Honorary Fellowship for Miss Younghusband

Miss Eileen Younghusband, C.B.E., J.P., has been given an Honorary Fellowship at the London School of Economics. She was formerly on the Executive Board of the World Federation for Mental Health and a member of our Social Services Committee. To many abroad as well as in this country, she is well known for the Ministry of Health Report on Social Workers which bears her name, and for the great contribution she has made to the training of social workers.

Lively Correspondence in "The Lancet"

Child Psychiatry and its relationship to Child Guidance (inclusive and exclusive) has raised controversy, and a lively discussion took place in the correspondence columns of the *British Medical Journal* and the *Lancet* during December. Our Clinical Services Committee had anticipated the correspondence by a special meeting to discuss the question and is continuing to study the subject.

Mental Health Guides for the General Practitioner

By ALFRED TORRIE, M.A., M.B., Ch.B., D.P.M.

The recent lists of specialists published by the Ministry of Health seem to have abolished the psychiatrist and substituted the term "mental health specialist". This is all to the good, but the status given to them by their medical colleagues who distribute merit awards places them at the bottom of the list, while at the top are the neurologists, to whom patients go suffering from "nerves", because it is more respectable than going to a mental health specialist.

One neurologist friend of mine says that over two-thirds of his practice ought to be in the field of the psychiatrist. Mental health is still a "pipe dream". The few mental *health* specialists are too busy coping with mental *disease*; not so much psychotic disorders as psychosomatic illness and emotional disabilities. The reviewer was Hon. Secretary of the Prevention and Early Treatment Committee of the National Council for Mental Hygiene a quarter of a century ago. It still remains a vision of what we hoped mental health would be. The progress we have made seems terribly small.

The reason for this is partly the psychiatrist's fault. There are three main schools of psychiatry in this country—the Right, Left, and Centre. The Right is the materialistic, physiological school to which the "safe" people belong, as it keeps well away from emotions of the patients and the doctors. The physical treatments it prescribes must bring a fortune to the pharmaceutical companies. The Left ignores the body altogether and sticks rigidly to a doctrinaire, dogmatic theory of human behaviour not far removed from animal behaviour. But, thank God, there is a growing Centre which thinks of the whole man and his doctor's relationship with him. It publishes "Mind and Medicine" Monographs, which many of us have been waiting for.

Compared with many medical schools in the U.S.A. and the standards set by World Health Organisation, the teaching of psychiatry in Britain is in a backward state. This was commented on in a publication by a Committee of the College of General Practitioners of research findings, in the *British Medical Journal* a few years ago. Only one medical school at present reaches the minimum number of hours demanded by W.H.O. during the six years of medical training. The British Medical Students' Association published a report on "The Teaching of Psychiatry and Psychological Medicine in British Medical Schools". The table of the hours given to this teaching (in 1958) varied enormously. So the family doctor must learn his psychological medicine after graduating. The "Centre" School of Psychiatry includes the Tavistock Clinic and owes much to the inspiration of Dr. Michael Balint. Since 1949, over 200 doctors have benefited from research-cum-training seminars on psychological problems in medical practice. Two books dealing

with this have been published: *The Doctor, His Patient and His Illness,* by Michael Balint (1957), and *Psychotherapeutic Techniques in Medicine,* by M. & E. Balint. I wish that during my ten years in general practice between the wars I had had access to books like these. It would have saved me many psychological mistakes.

Having just reviewed the second of these books for another journal, it is a disappointment to turn to the two I am now reviewing: *The Layman's Guide to Psychiatry,* by the Assistant Commissioner of Mental Hygiene, and a strangely titled booklet *How to Get and Hold Your Man,* by Fanian Parr.

The first book has four purposes: (1) The recognition that the broad problem of abnormal behaviour is something to be handled medically rather than legalistically; (2) to help readers who are emotionally disturbed but possess insight into their condition; (3) to give to relatives and friends of mental patients, particularly of those who are institutionalised, a clearer picture of what has been and what is being done to overcome the obstacles unique to this medical speciality; and (4) to be an aid to general practitioners, medical students, psychologists, social workers, occupational therapists and volunteer hospital aides, legislators, welfare officials, educators, attorneys and clergymen. It is a paper-back. I hope that it is not too nationalistic to say that some of our Pelican paper-backs do the job better.

The chapters cover the roots of mental illness, everyday tensions and anxieties, psychosomatic illness, psychoneurosis, psychosis, treatment, asocial behaviour, addiction, mental retardation, epilepsy, the formative years, the years of change, the later years, religion and psychiatry. You get a lot for a dollar-and-a-half. Those interested should buy it and judge for themselves.

I have space for only two comments. Five pages are devoted to the psychiatric problem of the widowed. The author's experience must have been with a group quite different from the ones who seek help in this country. He says they are "carefree, excessively extroverted, fun-seeking women". Widows in Britain subject to a rigid earnings rule of a maximum of £3 10s. are certainly not like that. The second comment is a denial of the truth of Dr. Brussel's statement about Jung that "his later incorporation of Nazism into his theories cost him a great loss of prestige". Jung himself has denied this charge emphatically in conversation with the reviewer.

It is a relief to turn to the second book, with the odd title *How to Get and Hold Your Man.* General practitioners are often the "guide, philosopher and friend" to families, and are often asked questions about the bringing up of children. This book has only a little over 100 pages but it is packed with practical advice which contains many sound mental health principles. A feature of the book with its telegraphic style is the frequent summaries. For those about to marry, for those who are looking for a mate, for those who are married, this little treasure of a book is a "vade-mecum".

Books reviewed in this article are: *The Layman's Guide to Psychiatry,* by James A. Brussel, M.D. Preface by Paul H. Hoch, M.D., Commissioner, Department of Mental Hygiene, New York State. Published by Barnes & Noble Inc., New York. $1.50, pp. 235. *How to Get and Hold Your Man,* by Fanian Parr. Published by Mail Order Books, 41a Seaforth Road, Liverpool 21. 10/-, pp. 111.

Reviews

Teaching the Slow-Learner in the Special School. Edited by M. F. Cleugh. Methuen. 30s.

Dr. Cleugh is in charge of the special one-year course for teachers of E.S.N. children at the University of London, Institute of Education. All the contributors to the symposium are her former students. Many aspects of school work and life are covered and the chapters are full of direct help to teachers and suggestions as to what to do and how to do it.

Perhaps the least satisfactory chapter is on "The Social, Moral and Religious Training of the E.S.N. Child". The practical suggestions in it are good but it is stretching things a little far to suggest that only since the time of Christianity has attention been paid to individuality. The Greeks both cherished and nurtured individuality, and there were times during the Byzantine Empire when this candle went out. Perhaps also, insufficient account is taken of the importance of early pre-school years in laying the basis of fundamental patterns of behaviour.

The chapter on physical education and health is good. Other chapters deal with play, speech, reading, arithmetic, art, music and drama, and there is an important chapter on the use of leisure.

Each chapter has a list of suggestions for further reading. It is a book than can be thoroughly recommended.

PETER SECRETAN

Mr. Fairweather and His Family. By Margaret Kornitzer. The Bodley Head. 9s. 6d.

Margaret Gill's delightful illustrations make this a pleasant book to hand to any young child. The pictures convey the spirit of the text which describes an ordinary couple and the way they adopted two children to complete their family. Even the social worker is shown in a sympathetic light and the subject of adoption is treated without sentimentality.

Miss Kornitzer has made for herself a unique position by her books on adoption.

ROBINA S. ADDIS

Mental Subnormality and Community Care. P.E.P. Broadsheet, No. 457. Obtainable from 16 Queen Anne's Gate, London, S.W.1. 3s. 6d.

This is the second Broadsheet arising out of the three-year study of community mental health services being carried on by P.E.P. under the direction of Dr. F. M. Martin, Edinburgh University.

It surveys the present situation in regard to mental subnormality in four sections—Legal Changes, Epidemiology, Local Authority and Hospital Services, and Research—the whole constituting a valuable summing up of current knowledge and trends and of the services available.

The need for more experimental research in every part of the field of mental subnormality is pointed out. With regard to training and education, for instance:

> "We know far too little about the relative effectiveness of different methods . . . and of different educational media, and

about the optimum size of groups, about the impact of emotional factors on learning and about the rôle of different types of incentives."

Another direction, in which detailed investigation is needed is in the use and limitations of the hostels which local health authorities are now empowered to provide.

A. L. HARGROVE

The Day Hospital Movement in Great Britain. By James Farndale, B.Com., F.H.A., M.R.S.H., Barrister-at-Law. Pergamon Press 84s. pp. 430.

The sub-title of this book gives all that is needed by way of description. It consists, as stated, of an "analysis and description of 65 Day Hospitals and Day Centres with special reference to Psychiatric and Geriatric Day Hospitals" visited by the author in 1958-59. It was written as a research project carried out whilst he was working in the Department of Social Administration, University of Manchester, as an Hon. Research Fellow seconded from the Bethlem Royal Hospital and the Maudsley Hospital.

As a book of reference it will be invaluable to members of Local Health Authorities planning this new type of mental health service as well as to doctors and social workers seeking to help patients in need of such facilities. Its price is high, but the text is interspersed by numerous photographic illustrations and there are clearly printed tables and maps, with lists and indexes to allow of quick and easy references.

A. L. HARGROVE

Correspondence

To the Editor
Mental Health

Dear Sir,

KEEPING IN TOUCH WITH NEW DEVELOPMENTS

No one would deny the necessity for more—and possibly better—teaching of psychiatry to medical students; particularly if, as has been suggested, this may result in an increase both quantitive and qualitative in those adopting psychiatry as their speciality. But to a layman this appears to be only a partial solution of the problem of the due application of psychological medicine to the healing of the sick.

Should not some means be found whereby those actually engaged in the practice of medicine could be enabled to keep in touch with developments both in psychology and in the total environment of modern man?

It is surely clear that if the Mental Health Act is to function satisfactorily a very much greater degree of co-operation must take place between the three branches of the N.H.S.

The problems presented by the two-way traffic as between general practitioner and hospital doctor are not simple; not even as simple as they would be in a completely integrated service but as for a variety of reasons this is not at present within the bounds of practical politics a partial solution should surely be sought. There are observable tendencies which seem to indicate that the problems involved are not entirely insoluble.

General practitioners are busy people and to leave a practice for a considerable time presents other difficulties also but with Ministerial blessing on Group Practice and with the slow growth of Health Centres it should be possible for an established G.P. to embark on a really intensive "refresher course" preferably in hospital as well as in the lecture room.

From the other angle hospital psychiatrists—out-patient clinics notwithstanding—still tend to be somewhat isolated from those whom they serve and domiciliary visits are not at present a satisfactory substitute. An exchange of personnel on a local and voluntary basis as between general practitioner and hospital doctor might with good will on both sides be arranged and it is not unknown for doctors with experience in general practice to act as locums in psychiatric hospitals. A start could perhaps also be made by an extension of the arrangement adopted in at least one hospital whereby the geriatric wards are in the care of general practitioners with a consultant psychiatrist available in case of need.

These are merely tentative suggestions and there must be many others for dealing with what would appear to the writer to be a matter of sufficient importance to merit consideration by the N.A.M.H.

Yours faithfully

HELEN M. KEYNES

London, S.W.7

Winter 1961/62

NEWS MH LETTER

ISSUED BY THE NATIONAL ASSOCIATION FOR MENTAL HEALTH
MAURICE CRAIG HOUSE · 39 QUEEN ANNE STREET · LONDON, W.1
TELEPHONE: WELBECK 1272 PRICE 3d.

Annual General Meeting of N.A.M.H.

The Royal Society of Medicine was crowded for the Annual General Meeting of the N.A.M.H., both during the formal business of the morning of November 21st and for the afternoon address by Dr. Russell Barton on Social Clubs for the Mentally Disordered. A report of Dr. Barton's address is printed in the current issue of *Mental Health*.

Questions and discussion were lively at both sessions of the A.G.M. As usual one particular feature was the giving of reports by two of the local Associations. This year it was the turn of Cambridgeshire and Bradford. We give their news below.

Cambridgeshire's Mental Welfare Association was founded in 1908. From 1915 it received a grant from the Cambridgeshire County Council in consideration of statutory functions it undertook on the Council's behalf and shortly afterwards Fulbourn Hospital asked the Association for home reports on patients suffering from mental illness.

The Association is still used by the local authorities and undertakes much of the domiciliary work in Cambridge and Cambridgeshire amongst the mentally disordered. Close co-operation exists between the Association's staff (who are designated mental welfare officers of the County Council), the staff of Fulbourn and Addenbrooke's Hospitals, the local authorities, and other voluntary agencies, including the Cambridge Society for Mentally Handicapped Children.

The Association's activities from voluntary funds include a workshop for the mentally subnormal which opened in mid-September. Evening classes are run for assistance with reading and writing and social activities. For the mentally ill the Association provides a good neighbour service, assistance at a psychiatric club run by the hospital, a car service, and a panel of interpreters for any emergency. Meetings are held, both for the general public and for selected professional groups. Financial and other material assistance is given to needy patients.

Bradford. In contrast, the association was formed only 19 months ago. Mrs. Callaway, of the Northern Branch of the N.A.M.H., encouraged a few active people to meet and an inaugural meeting was addressed by the Lord Mayor, Lady

Norman and Dr. Valentine. Three permanent sub-committees, on Practical Services, Education and Appeals have been set up. All work closely with the Local Authorities concerned.

The Practical Services Sub-Committee regularly visits and reports upon elderly confused people. They also run Social Clubs for mentally handicapped children, one for boys and one for girls. Last summer they took them all on a day's outing in the Yorkshire Dales. They have also now opened an afternoon social club for ex-patients in Bradford, and a cot service for severely mentally handicapped children. A car service is organised to enable patients at Menston Hospital to be visited by elderly or infirm relatives from Bradford.

The Education sub-committee has held five film shows and discussions. In April 1961, a Day Conference on "New Perspectives on Mental Illness and Psychiatry" was organised jointly with the Leeds University Extension Centre in Bradford; and a Conference on the rehabilitation of the short-term patient is planned for next April.

The Appeals Sub-Committee organised a Flag Day in Bradford on Whit Saturday which—although not the easiest of days—was very successful. Funds also came from the proceeds of a fashion show and coffee mornings and other efforts kindly organised by lady helpers in the area.

The Association has been registered as a charity and its first legacy and first covenanted subscription have been received.

Mental Health Research Fund A.G.M.

On November 20th the Royal Society of Medicine had been the venue for the A.G.M. of the Mental Health Research Fund. The Chairman, Mr. Ian T. Henderson, appealed for much more support to supplement "the present slender resources" of the Fund and expressed grave concern at the absence of a proper structure of research posts in the field of mental health.

He stressed that "Again and again we have come across cases where first-class research workers have been lost to the field because of lack of permanent posts to which they might aspire. . . "

Mr. Henderson announced that during the year ending March 31st, 1961 the Fund had made 20 new research grants, bringing the total number to 116 during the six years in which the Fund had been making such grants.

Art and Schizophrenia Lecture

Following Mr. Henderson's address, Professor G. M. Carstairs, Professor of Psychological Medicine at the University of Edinburgh and member of the Fund's Research Committee, lectured on *Gifted Schizophrenics,* illustrating his talk with a film and colour slides showing paintings by schizophrenics and by artists showing schizophrenic behaviour. These included examples of the work of Louis Wain, Edward Munch, Odilon Redon, Vincent Van Gogh, and

the unknown flower-painter whose book of illustrations is preserved in the Guttman-Maclay collection, and showed the transition from a relatively "everyday" world to a bizarrely heightened and distorted perception.

In his lecture Professor Carstairs commented that schizophrenia is no respecter of persons, afflicting rich and poor, intelligent and stupid, the gifted and untalented alike. From the patient's viewpoint its visitation was always unwelcome, bringing suffering and handicaps, but in this ressembling the mixed blessing of unusual artistic sensibility, for like the artist, the schizophrenic sees the world differently from ordinary people, preserving that acuteness of perception described by Sir Herbert Read as "the innocent eye". For the schizophrenic, however, this increased awareness is heightened by dread, for he is aware of an element of threat in his surroundings. This is particularly strong during the active stage of his illness, which sometimes recurs with renewed intensity after a period of relative calm.

In ending his lecture Professor Carstairs referred to the new world opened up for ordinary people by schizophrenic art, so that, looking on, we were suddenly reminded how limited our humdrum perceptions have become, and for a moment, as in the flash of artistic perception, a new dimension of experience is revealed to us.

Exhibition of Art from Mental Hospitals

It is hoped that examples of paintings and sculptures by schizophrenics and other patients suffering from mental illness will be brought before the public at an exhibition organised by the National Appeal in October. Lady Monckton chaired a meeting at N.A.M.H. Headquarters on February 6th which discussed its organisation. Mr. Jacques O'Hana has offered to lend his gallery in Carlos Place, W.1, for ten days, and it is hoped to select pictures from mental hospitals all over the country. Teachers of art therapy in mental hospitals, artists and critics, psychiatrists and others concerned with the exhibition of schizophrenic art in 1955 were all invited to the meeting.

Annual Meeting of Local Associations

At the Annual Meeting of Local Associations of the N.A.M.H. on November 20th, Lord Feversham spoke of the growing role to be played by the Local Associations in the work of the N.A.M.H., and described them as a bridge between the hospital and the community.

With the opening of the brains trust session on the theme of "working together—professional and volunteer," the Chair was taken by Mrs. Mary Stocks. Panel members were Mr. James Farndale, Deputy Governor of the Bethlem Royal and Maudsley Hospitals, Miss V. M. Jenkins, Senior P.S.W. for Fairdene and Netherne Hospitals, Mr. K. A. McCallum, Mental Welfare Officer in the Yeovil area and Dr. Elizabeth Tylden, Co-founder of The Stepping Stones Club in Bromley.

Subjects discussed included the problem of lay after-care for patients returning to the community; the varying means whereby those willing to assist in some way with voluntary work on mental health can be used; the effects and kinds of depression from which people suffer; the valuable work which Local Associations can do in persuading ex-patients to join outside organisations; and the advisability or otherwise of making another attempt to link voluntary societies for mental health into one organisation.

Throughout the discussion the ways in which Local Associations can and do help both with current and ex-patients was particularly stressed. The invaluable role played by voluntary helpers in such clubs as the Stepping Stones was underlined. The importance of Associations as pressure-groups within the public as a whole for better understanding of mental health was emphasised, as well as such practical assistance as the provision of day-sitters with geriatric patients, help with the running of classes for patients, joining Leagues of Hospital Friends and the provision of transport for patients.

Residential Services

Hostels for E.S.N. Adolescents. Both Fairhaven Hostel for Boys and Fairlop House Hostel for Girls have been busy with Christmas activities. Each hostel had a very successful Christmas party. At Fairhaven a large number of friends and old boys attended. We were very pleased to see the old boys, and those who came are making good progress since their departure from the hostel. At Fairhaven we were very pleased to welcome Mrs. Middleton, the Mayor of Greenwich.

All the girls went away for Christmas to friends or relatives and quite a number of the boys returned home. A few boys stayed behind at Fairhaven Hostel and had a most enjoyable time.

Since the last *Newsletter* we have had more applications for both boys and girls, but there are still vacancies at the hostels.

Parnham. It is with very great pleasure that we report that everything at Parnham is going very well under the guidance of our new wardens Mr. and Mrs. Kenny, and the advice of our very active Management Committee there.

In the winter our residents are not able to go out so much, and their coach trips are postponed until the warmer weather comes again, but it is impressive to see how well they undertake knitting and the making of soft toys and similar articles under the encouragement of Miss Parry, our occupational therapist who has given us loyal service for many years.

A very happy Christmas was enjoyed by everyone at the home. Several special activities were arranged, including a carol concert by local children.

Orchard Dene. Mrs. Turton, our temporary matron has done splendid work at this home during the summer and autumn; it has not been an easy time, for as we reported in our last issue, the future of the home remains a little uncertain, although it is encouraging that the numbers of children in the home have

remained as high—and probably even a little higher—than normal for this time of year, and we hope that now the fees have been increased we shall be able to keep the home going. Despite the difficulties, the children, as usual, were all given a very happy Christmas.

Duncroft Approved School. A most successful Christmas party was held on December 16th. Building has now begun on the new hostel, which will be opened in the latter half of this year.

Staff Changes

At the end of November, we said "Goodbye" to Miss Carol Mann, S.R.N., who for nine years had been a member of the Residential Services Department's staff. Her long experience of nursing enabled us to send her to the assistance of the Homes—particularly Orchard Dene and Parnham—when crises occurred needing Headquarters' help. She always accepted with alacrity and carried out these tasks with skill and devotion.

We shall miss her and she takes with her our affectionate wishes for a retirement giving not a "well earned rest" but new and interesting opportunities of further service.

On December 29th we also said goodbye to Miss Hargrove and presented her with a transistor radio on her retirement from her post with the N.A.M.H. We wrote in the last *Newsletter* of Miss Hargrove's unrivalled services to the mentally handicapped. We are delighted to let our readers know that Miss Hargrove—at the request of the Association's Editorial Board—is now beginning work on the preparation of a manuscript on the subject of *50 Years of Voluntary Work for the Mentally Handicapped,* to cover the half-century up to the 1959 Mental Health Act.

We expect to see and welcome her back to Headquarters on many occasions.

There is another new face in the Public Information Department, for Miss Sybil Mawdesley has joined us from *Vogue* as N.A.M.H. Publications Manager, while the Northern Office has welcomed Mrs. D. Walker as Administrative Assistant to Residential Services.

N.A.M.H. Courses and Conferences

"Violence and the Mental Health Services"

The Association is holding its 1962 Annual Conference on this subject at Church House, Westminster, S.W.1. on March 8th and 9th. The Conference will be opened by the Rt. Hon. Lord Devlin under the Chairmanship of the Rt. Hon. R. A. Butler, C.H., M.P. Other speakers include Baroness Wootton, Dr. D. Stafford-Clarke and Dr. R. M. Jackson (under the Chairmanship of Christopher Mayhew, M.P.), Dr. H. B. Kidd, Dr. Michael Craft, Dr. T. M. Cuthbert (under the Chairmanship of Professor Desmond Curran), Dr. Donald J. West and Professor Hill (under the Chairmanship of Mr. Justice McVeigh).

Application forms should be obtained from the Conference Secretary.

Homes and Registration—Successful Conference

Homes for mentally subnormal patients previously "approved" or "certified" by the Board of Control are now being registered by Local Authorities under Part III of the Mental Health Act as either Mental Nursing Homes or Residential Homes.

This change has involved new administrative arrangements which in some cases have brought difficulties in their train, and in order to find out whether there was any way in which we could help, we asked Superintendents to tell us whether they would welcome an informal Conference to discuss the situation. A number of replies in the affirmative were received and the Conference was held at the office on December 5th attended by representatives of 12 Homes, (several others being unfortunately prevented from attending at the last moment). The proceedings, both at the morning and afternoon sessions, took the form of a Brains Trust with a panel composed of The Lady Adrian (President, Cambridgeshire Mental Welfare Association), Dr. W. Lumsden Walker (Medical Superintendent, Hortham Hospital, near Bristol, and N.A.M.H. Adviser on Mental Subnormality), and Dr. Guy Wigley (Deputy County Medical Officer of Health, Middlesex).

A number of questions had been sent in, and great appreciation of the way in which they were dealt with by members of the Panel was expressed. Its members and the N.A.M.H. staff were equally appreciative of the value of the opportunity of "getting together" and exchanging experiences.

The hope was expressed that a gathering of the kind might be held periodically as Superintendents of Homes have normally little contact with each other and the chances of discussing problems among one another are all too rare.

1962 Child Guidance Interclinic Conference

The London School of Economics will be the meeting-place for the N.A.M.H.'s eighteenth Child Guidance Clinic Conference on April 13th and 14th. The theme is to be *Clinical Problems of Young Children*. Membership of the Conference will be open to past and present members of Child Guidance teams and to Child Guidance students in training. The speakers will include Miss Anna Freud, Dr. Kenneth Soddy and Dr. John Apley, the Chairman will be Dr. A. D. B. Clarke.

November Day Conference on Ingleby Report

Following the success of the 1961 Child Guidance Inter-Clinic Conference on "The Child Guidance Clinic and Delinquency" a one-day Conference was held in London on November 15th. It was open to all interested in problems of the young delinquent, and attracted an audience of 250, including probation officers, school teachers, child care workers, child guidance clinic staffs and many other key workers in this sphere.

Informal Meeting of Doctors and Clergy at Headquarters

On January 24th Dr. T. P. Rees was in the chair for an informal evening meeting of doctors working in the field of mental health and Ministers of Religion, called by the N.A.M.H. to discuss how its resources and experience in the field of *Religion and*

Mental Health can be used to the best advantage. The meeting was yet another step in effecting closer co-operation betwen the two groups.

Courses for School Medical Officers

Two such courses will be held this year under the joint auspices of the N.A.M.H. and the University of London extra-mural Department, as well as one supplementary course. All applications must be made through the Local Health Authority.

Another Weekend Course for G.P.s

The N.A.M.H. is holding another weekend course for G.P.s from May 18th—20th.

Mental Health National Appeal

London Flag Day. When the accounts were closed on November 30th the total received from the London Flag Day (including donations) was £21,739 18s. 1d.; a rise of over £5,000 on the 1960 figure. In addition the gift of shares we mentioned in the last *Newsletter* had risen in value to £4,300. Mrs. R. A. Butler has again agreed to be President of the Flag Day in 1962, and the date has been fixed as June 5th; all kind helpers please note! By very kind permission of the Benchers, the Flag Day party for borough organisers, depot holders and key sellers will be held in the Inner Temple Hall on March 21st from 4.15-6 p.m.

Provincial Flag Days. Final results from Essex and West Suffolk, both organised by Miss Townsend, were £1,834 9s. 6d. in Essex and £350 for West Suffolk, the first year of collection. The 1962 Flag Day in Essex will be held on May 19th, and in Bucks on June 23rd.

Other Contributions. An anonymous gift of £5,000 has been received by the National Appeal, and more than £300 came in during a few weeks from subscribers who had received the Annual Report of the Appeal in its new independent form.

Mayor of Westminster's Film Premiere. The Mayor has adopted mental health as his special charity. A film premiere was held at the Odeon Theatre, Leicester Square on January 4th, at 7.45 p.m. in the presence of H.R.H. Princess Marina, Duchess of Kent, when John Mills starred in Jon Penington's production of "The Valiant".

The proceeds from an absolutely packed audience will be divided between the N.A.M.H., the M.H.R.F., the National Society for Mentally Handicapped Children, the Mental After-Care Association and the Ex-Services Mental Welfare Society.

Carol Singing Parties. Permits, folding collection boxes and carol sheets were supplied to a number of school, church, and other groups got together by voluntary organisations to sing carols during December. Many had also sung for the Appeal in 1960. Full results will not be known until the end of January 1962, but at present over £200 has been received.

Mistletoe Ball, December 20th, 1961. 364 tickets were sold for the second Mistletoe Ball for fifteen year-olds and over at the Chelsea Town Hall. The total from the sale of tickets and donations was £433, and the nett profit about £150. Lady Monckton,

President of the ball gave away the prizes, which—owing to the generosity of the Ball committee and members of the National Appeal Committee—numbered about fifty. There was excellent press publicity.

Local Associations

The Northern Branch is happy to announce the formation of two new local associations; on November 28th, in Scarborough and in Durham on December 13th. Both areas held public launching meetings which were well attended.

In *Scarborough* the meeting was presided over by the Mayor, Mr. W. H. Smith J.P. and the main speaker was Mr. Woodford, Chairman of the Northern Branch, who outlined the work of the N.A.M.H. Representatives were also present from Clifton Hospital, and the North Riding County Council Health Department sent its two Mental Health Officers, Miss A. Bray and Mr. F. Watson.

The meeting in *Durham* was held in the Town Hall, Mrs. Haworth presiding. Speakers included Dr. Duggan-Keen, Senior Consultant Psychiatrist and Medical Superintendent, Winterton Hospital; Dr. Ludkin, Deputy County Medical Officer of Health; Mr. F. E. Hurrell, Vice-President, Winterton Hospital League of Friends, and the Northern Secretary. The Friends of Winterton Hospital played a major part in making arrangements for the meeting and the Northern Branch is indebted to them.

We were delighted to hear that the first local association has ben formed in Wales, to be called the *Swansea and District Association for Mental Health*. It held its first general meeting on November 21st, 1961 and has now applied formally for affiliation to the N.A.M.H.

Canon H. Williams has been elected Chairman, Mrs. O. V. Riordan Secrtary, and Mr. J. Heywood Treasurer, and the Hospital Day Centre will be the headquarters of the association.

Plans are now being discussed for the special Local Associations' Conference in London requested at the 1961 Local Associations' Annual Meeting. The date seems likely to be a Saturday in late Spring or early Summer. Following recent custom, there will be a Spring Local Associations' Conference in the North.

Record Sale of Christmas Cards

The Association's Christmas Cards have never been so popular. About 350,000 were sold last year and final estimates are now being made of the income this will represent. We would like to thank everyone who helped to make this magnificent sales' figure possible. This help is very much appreciated.

Publications

"Hostels and the Mental Health Act" was published in January. Sold at 3s. 6d. it incorporates papers given at Conferences held in London and Leeds.

The next edition of the *Child Guidance Directory* is at the printers, and a new pamphlet, *Do Teenagers Have Wisdom?*, is about to go to press.

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